

AFFIX PATIENT INFO LABEL HERE

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

Hackensack University Medical Center  
**Pediatric Nephrology**  
**Patient & Family History**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Yrs \_\_\_ Months: \_\_\_  
 Form filled out by: \_\_\_\_\_ Relationship: \_\_\_\_\_

In a few words, why are you here to see the doctor today? \_\_\_\_\_

Who referred your child to the HUMC Pediatric Nephrology Clinic? *(Please include Name, Address, & Phone#)*  
 \_\_\_\_\_

If different, who is your child's primary care provider? \_\_\_\_\_

**BIRTH HISTORY:**

Adopted?  NO  YES Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Birth length: \_\_\_\_\_ inches.  
 Full Term:  NO  YES if NO, how early? \_\_\_\_\_ weeks Circumcision?  NO  YES  Not Applicable  
 Were there any problems with:  
 Pregnancy:  NO  YES Labor & Delivery:  NO  YES Neonatal Period:  NO  YES  
 Explain: \_\_\_\_\_

**GROWTH & DEVELOPMENT:**

Do you have any concerns regarding your child's growth and development?  NO  YES

**MENSTRUAL HISTORY:** Age of onset: \_\_\_\_\_  Regular  Irregular Explain: \_\_\_\_\_

**FAMILY HISTORY:**

Sibling(s) name(s) with age(s) \_\_\_\_\_  
*Are there any illnesses that run in the family (example: cancer)?*  
 Does anyone in the family have a condition listed below:  
 Kidney Disease  NO  YES Diabetes  NO  YES Kidney Stones  NO  YES  
 Blood in the urine  NO  YES Deafness  NO  YES Need for dialysis  NO  YES  
 High Blood Pressure (Hypertension)  NO  YES  
 Explain any YES answers \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Has your child ever been hospitalized?  NO  YES If YES, where? \_\_\_\_\_  
 Explain: \_\_\_\_\_ Date: \_\_\_\_\_  
 Has your child had any surgery?  NO  YES If YES, where? \_\_\_\_\_  
 Explain: \_\_\_\_\_ Date: \_\_\_\_\_  
 Does your child have any chronic medical conditions (examples: asthma, constipation)?  NO  YES  
 Explain: \_\_\_\_\_  
 Has your child had any significant medical or psychiatric illnesses in the past?  NO  YES  
 Explain: \_\_\_\_\_  
 Immunizations up to date?  NO  YES / Normal Audio/Vision screen?  NO  YES / Negative TB screen?  NO  YES

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**REVIEW OF SYSTEMS:**

Is your child having any of these issues right now or in the recent past?

- |   |  |  |  |
|---|--|--|--|
| Weight changes, malaise                     | <input type="checkbox"/> NO <input type="checkbox"/> YES | Headache, dizziness                        | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Pain anywhere                               | <input type="checkbox"/> NO <input type="checkbox"/> YES | Blurry vision, double vision               | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Puffiness around the eyes                   | <input type="checkbox"/> NO <input type="checkbox"/> YES | Fast heart beat, chest pain                | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Cough, shortness of breath                  | <input type="checkbox"/> NO <input type="checkbox"/> YES | Abdominal pain, swelling                   | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Rash, unexplained fevers                    | <input type="checkbox"/> NO <input type="checkbox"/> YES | Difficulty concentrating                   | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Frequent urination, Infrequent urination    | <input type="checkbox"/> NO <input type="checkbox"/> YES | Burning with urination, Blood in the urine | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Night time bedwetting, Daytime incontinence | <input type="checkbox"/> NO <input type="checkbox"/> YES | Ankle swelling, Joint pains                | <input type="checkbox"/> NO <input type="checkbox"/> YES |

Explain any YES answers above \_\_\_\_\_

My child feels well right now  NO  YES

**MEDICATIONS (including over-the-counter):**

Past medications: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies to Medicine: \_\_\_\_\_ Other Allergies: \_\_\_\_\_

**SOCIAL HISTORY:**

Who lives with the patient (*relation & ages*)? \_\_\_\_\_

What grade is your child in? \_\_\_\_\_ How is your child's attendance record? \_\_\_\_\_

How is your child's school performance? \_\_\_\_\_

Does your child work? \_\_\_\_\_

Is there anything else that you want the doctor to know? Do you have an important question that you want the doctor to answer?  NO  YES \_\_\_\_\_

**LIST ALL OTHER PHYSICIAN(S) WHO HAVE BEEN INVOLVED IN YOUR CHILD'S CARE:**

- |                      |                  |   |
|----------------------|------------------|---|
| Doctor's Name: _____ | Speciality _____ | Send visit<br>letter to: <input type="checkbox"/> |
| Address: _____       |                  | Tel# _____  |
| Doctor's Name: _____ | Speciality _____ | <input type="checkbox"/>                          |
| Address: _____       |                  | Tel# _____  |
| Doctor's Name: _____ | Speciality _____ | <input type="checkbox"/>                          |
| Address: _____       |                  | Tel# _____  |